Hertfordshire Partnership **NHS**
University NHS Foundation Trust

HPFT

Delivery of Care Policy

Incorporating the Care Programme Approach

HPFT Policy and Procedure

Version	6
Executive Lead	Executive Director Quality and Medical Leadership
Lead Author	Clinical Director for West SBU and Clinical Director for East & North SBU
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Target Audience	This Policy must be understood by all operational staff working in the Trust

Title of document	Delivery of Care		
Document Type	Policy		
Ratifying Committee	Quality and Risk Management Committee		
Version	Issue Date	Review Date	Lead Author
6	13/06/2019	13/06/2022	Clinical Director for West SBU and Clinical Director for East & North SBU
Staff need to know about this policy because (complete in 50 words)	This details the roles and responsibilities of staff in relation to the oversight and processes in relation to management of the Delivery of Care across the Trust.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	This policy describes the Trust systems for delivering care to each service user. It includes care co-ordination under Care Programme Approach (CPA) as defined by national policy frameworks. CPA is now the only form of care co-ordination used by the Trust, as those on Standard Care have a contact person or team rather than a care co-ordinator. It is the responsibility of the assessor to decide whose care should be co-ordinated via CPA and to record the decision promptly		
Summary of significant changes from previous version are:	None		

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1.   Summary

This policy relates to the organisation of care for all service users of Hertfordshire Partnership University NHS Foundation Trust (HPFT) (the Trust). It describes the framework to deliver safe and effective care in partnership with those who use Trust services.

It deals with all types of care delivery that may be used in the Trust to provide care and treatment. It recognises that service users are responsible for their own care, in partnership with HPFT and other agencies and carers where applicable and appropriate.

It further recognises that many service users will have contact with only one member of staff only in HPFT; they do not need ongoing co-ordination of care, but will be part of team caseload with a named contact person or team who will work in partnership with the service user to support their care in HPFT.

2.   Purpose

This policy describes the Trust systems for delivering care to each service user. It includes care co-ordination under Care Programme Approach (CPA) as defined by national policy frameworks.

It is essential that all service users and their carers understand how their HPFT care is organised, who their contact person is and how we plan to help them.

3.   Eligibility

CPA is now the only form of care co-ordination used by the Trust, as those on Standard Care have a contact person or team rather than a care co-ordinator.

From October 2008 there has been only one level of CPA set nationally and this policy will be amended as national direction is received.

All those receiving secondary mental health services should be considered for CPA. This takes place at initial assessment and as needs significantly change.

The characteristics to consider when deciding if CPA is needed are quoted as follows from "Refocusing the Care Programme Approach" DoH (March 2008):

> Severe Mental Disorder (including personality disorder) with a high degree of clinical complexity

> Current or potential risk(s), including:

- Suicide, persistent and severe self-harm, harm to others (including history of offending)
- Relapse history requiring urgent response
- Self-neglect/non concordance with treatment plan
- Vulnerable adult; adult/child protection e.g.
    - Exploitation e.g. financial/sexual
    - Financial difficulties related to mental illness
    - Disinhibition
    - Physical/emotional abuse
    - Cognitive impairment
    - Child protection issues

>Current or significant history of severe distress/instability or disengagement

>Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse, learning disability.

>Multiple service provision from different agencies, including; housing, physical care, employment, criminal justice, voluntary agencies.

>Currently / recently detained under Mental Health Act or referred to crisis/home treatment team.

>Significant reliance on carer(s) or has own significant caring responsibilities.

>Experiencing disadvantage or difficulty as a result of:-

- Parenting responsibilities (including pregnancy)
- Physical health problems (including disabilities)
- Unsettled accommodation /housing issues
- Employment issues when mentally ill

- Significant impairment of function due to mental illness
- Any other issues relating to being from a particular protected group. (E.g. ethnicity, religion, sexual orientation etc.)

The following points should be noted:

- There is not a minimum or critical number of items on the list that should indicate the need for CPA

- All inpatients will be on CPA

- Service users on Clozapine will be on CPA.

- All CATT and Children's CATT service users will be on CPA

- All service users open to Older Adults Crisis Function should be on CPA

- All those in funded social care placements will be on CPA. However, we will not routinely allocate a named Care Co-ordinator to all service users in funded placements if they are assessed as settled. We will continue to review their care annually as CPA is a useful framework to ensure this annual review is undertaken.

- All those where there is an ongoing child protection plan for a child for whom a service user has parental responsibility will be on CPA

- Service users who have a diagnosis of a serious mental illness and active alcohol and/or substance misuse will be on CPA.

- All those subject to Supervised Community Treatment or to guardianship under the Mental Health Act will be on CPA

- Those to whom section 117 (Mental Health Act 1983) applies will not be on CPA for this reason alone

- These criteria place an emphasis on service users who have parenting responsibilities or significant caring responsibilities, who have dual diagnosis, who have a history of violence or self-harm, and who are in unsettled accommodation

- CPA should be seen as a means of ensuring that those who most need a rigorous and thorough system of care co-ordination receive it.

4. The Care Co-ordinator's Role

Every service user on CPA will either have a named individual Care Co-ordinator named team contact details for the individual or team responsible for their care.

The allocation of a named individual Care Co-ordinator will be prioritised to those service users who fulfil CPA criteria and most need the allocation of a named individual who offers active care and support to service users on a Trust care pathway.

If an individual CPA Care Co-ordinator is allocated this will be taken by a professionally qualified member of the multi-disciplinary team who is well placed to oversee care planning, risk management and resource allocation and who is employed in a community role.

Service users who are waiting for the allocation of a named individual care coordinator will understand the arrangements for their care, and what team they can contact for support.

Judgements as to whether locum or temporary staff should undertake the role of care coordinator need to be taken on a case by case basis, taking into account continuity of care for the service user and individual staff's familiarity with the role and responsibilities of Care Co-ordinator.

Students, vocational adviser and trainees including junior doctors will not undertake the role of CPA care co-ordinator. Psychiatrists will not act as care co-ordinators.

The Care Co-ordinator named team is responsible for keeping in close contact with the service user and for advising other members of the care team of changes in the circumstances of the service user which might require review or modification of the care plan and the risk assessment/management plan

It is important that the Care Co-ordinator is trusted by the service user and the service users own views as to the most appropriate person for this role should be sought. Where possible this should be agreed, however there may be occasions when the service user's wishes cannot be met and an alternative Care Co-ordinator may need to be allocated.

In identifying a suitable Care Co-ordinator, consideration must be given to the gender, ethnicity and cultural beliefs of the service user. Responsibility for ensuring the allocation of the Care Co-ordinator's role within multi-disciplinary cases rests with the relevant team manager.

5. CPA Care Plan

A service user on CPA must receive a written copy of their care plan within five working days of their first meeting with the allocated Care Co-ordinator.

The care plan should be devised and written with the involvement of the service user, using the service user's preferred form of words where possible. Where appropriate and practicable, alternative accessible formats should be utilised for service users who have specific disabilities. The care plan must:

- State the Care Co-ordinator's name and contact details

- Identify the interventions and anticipated outcomes
- Record all the actions necessary to achieve service user-defined goals
- Set out estimated timescales by which outcomes or goals will be achieved or reviewed
- Describe the contributions of all agencies and carers/family members involved
- Include a contingency plan which also acts as a crisis plan (with details of other sources of support such as the helpline when the Care Co-ordinator is not available)
- Be understandable and meaningful to the service user
- Be agreed by the service user and signed by them (the electronic service user record cannot be signed), with reasons noted in the instances where the service user feels unable to sign
- Be signed by the Care Co-ordinator
- Be copied to the carer (where the service user is in agreement).

6. Decision to use CPA

It is the responsibility of the assessor to decide whose care should be co-ordinated via CPA and to record the decision promptly.

Once the assessor has decided that the criteria for CPA are met and a Care Co-ordinator has been allocated, or named team confirmed, the Care Co-ordinator or team should:

- Give information to the service user (and carer as appropriate) about CPA
- Compile the care plan as outlined above in negotiation with the service user (and carer where appropriate)
- Liaise as necessary with other contributors to the care plan – both within and outside the Trust – to obtain their agreement
- Record the care plan on the EPR, give a copy to the service user and carer where appropriate and obtain the service user's signature when they have the capacity to consent
- Ensure all contributors to the care plan know what their role is, and for partner agencies (including in every case the GP), guarantee this by sending them a copy of the care plan

7. CPA Review

All service users on CPA will have a minimum of one review per year.

CPA meetings may occur within community or hospital settings and should be used to fulfil statutory requirements in accordance with Section 117, Mental Health Act (aftercare).

These meetings will be convened by the Care Co-ordinator or named team. They should be approached in a flexible manner which most encourages full service user involvement. The Care Co-ordinator or team representative should ask the service

user if they wish to be supported by an advocate at such meetings and make the necessary arrangements if required.

The Care Co-ordinator or team representative will also need to ensure that all those involved in the service user's care have given their views in advance of the meeting, and that they are fully and promptly informed of outcomes thereafter.

The purpose of a CPA review is therefore:

- To revisit the service user's goals and aspirations and check progress towards recovery
- To review the working of the care plan and risk management plan
- To ensure the completion of a Physical Health Assessment
- To ensure that all Physical Health needs are monitored and addressed and communicated to the GP
- To revise the care plan and risk assessment as necessary
- To review any care commissioned under care management arrangements
- To consider whether there is a need to discharge the individual from CPA to standard care.

CPA Review meetings will be held in the following circumstances:
- Routinely on an annual basis
- When the service user's situation has become so stable that they no longer meet the criteria for CPA.
- Where the care plan needs review as it is proving ineffective in managing current risks or meeting current needs
- Where the care co-ordination role needs to be transferred because care is being transferred between teams or between Trusts – this will always happen when the care of a service user is transferred from the Acute Care Pathway to another service area.

CPA review meetings need not involve anyone other than the service user, the carer (where appropriate), the Care Co-ordinator or team representative, and where care is being transferred, a representative of the other service.

However, the Care Co-ordinator will consider with the service user and carer where appropriate who should attend the meeting so that communication between those involved is at its best. If they agree that a meeting of all those involved is necessary to ensure this, the Care Co-ordinator will arrange this.

Prior to any CPA review that involves a decision about moving a service users care the Care Co-ordinator and a member of the placement team must have seen the service user at their residential address in the last 3 months in order to have a current understanding of their risk, care and future needs.

The Care Co-ordinator will ensure arrangements are in place to properly record the new care plan onto the EPR and to communicate it to all parties.

The care co-ordination review form on the EPR followed by a new care plan will be used to summarise the outcome of a CPA Review meeting.

Following CPA meetings, letters (to include summary of physical health checks) are to be sent to GP within 10 working days

8.   Review in Acute Mental Health Care

The 7 days after transfer from acute inpatient care, with the risk peaking on day 3 and from any acute care pathway service are a well-known high risk period for many service users (see "Transfer and Discharge of Service Users within the Care Planning Process" policy). Good transfer planning is thus as important as ever.

To ensure a safe and effective transfer of care from the Acute Care Pathway to other Trust services or to full discharge from Trust services to GP, a CPA Review must be held.

A CPA Review should be held before transfer from the Acute Care Pathway to other Trust Services, to Primary Care or to another mental health service provider.

The CPA meeting should at least involve the service user, the carer (where appropriate), the service user's named nurse (or their representative), their Acute Care Consultant Psychiatrist (or their representative) and the Care Co-ordinator if one is allocated.

In exceptional circumstances, such as when an unplanned transfer occurs (e.g if the service user leaves hospital against medical advice), the CPA meeting must take place within 7 days of unplanned transfer.

It is essential that at every transfer CPA meeting the service user and carer (where appropriate) is given a copy of their care plan. This should include the contact details of the Care Co-ordinator and when their first community appointment is if transferred to other Trust services. If the plan is to discharge to primary care or to another agency, written information should be provided to the service user, carer where appropriate, GP and other agencies that will remain involved in care describing what is needed – from the service user, carers and other sources – for the service user to continue their recovery. This should include the service user being aware of their relapse signature.

Those service users who have left hospital (and remain on CPA) must be followed up with a face-to-face appointment within 72 hours of leaving hospital. This would usually be done by the CAT team (if taken on for home treatment), or service user's relevant team.

Those service users who have been transferred from any Acute Care Pathway service to an Adult Community Mental Health Service on CPA must be followed up by a face to face appointment within 72 hours of the transfer date. This would usually be done by the service user's Care Co-ordinator.

9.   Discharge from CPA

Service users will be discharged from CPA in the following circumstances:
- Where their care is transferred under CPA to another Trust
- Where they no longer meet criteria for CPA but will continue to be managed under Standard Care
- Where they are to be discharged back to primary care

It is accepted that in some cases a service user will disengage from services themselves. In these cases a CPA review meeting should be convened to confirm the disengagement from services and to record a recommended plan of care to address outstanding known needs of the service user.

The meeting should go ahead even if the service user chooses to not attend. The record of the meeting should be copied to the service user, carer (where permission has been given) their GP and any other involved agencies. If the decision is taken to discharge the service user, the record should include information about how the service user can re-access services in the future if they are required. Where the service user lacks capacity, team should act in the service user's best interests.

A thorough risk assessment, with full service user and carer involvement where possible, will be undertaken before a decision is made that the support of CPA, or of any trust services, is no longer required.

Discharge from CPA will not take place without:
- Review and handover (e.g. to the named practitioner or GP)
- Exchange of appropriate information with all concerned including carers, where appropriate showing how the service user is advised to maintain and continue their recovery
- A clear statement about the action to take, and who to contact, in the event of relapse

10. Summary

Standard Care may also be known as "non-CPA".

Having had an initial assessment of health and social care needs, service users will be told whether their care will be managed under CPA or not (with explanation of what this entails).

The majority of service users will not require care co-ordination. These will be people who will require more straight forward treatment or a brief intervention and who will generally only see one Trust staff member at a time.

Under Standard Care, the documentation of care plan, review and risk will differ from CPA. It will be contained in letter templates.

Standard care will apply to:
- Those under outpatients care only (through clinics, appointments or visits) – whether provided by a psychiatrist, CPN, social worker, psychologist or other mental health professional
- Those in the maintenance phase of the EMDASS service

Individuals assessed as requiring Standard Care will all have a named practitioner or team.

In such cases the following is required:
- EPR registration and minimum data set on the EPR
- Regular communication with the GP
- A care plan, (which will be in the form of a GP letter as long as it is clearly labelled as a care plan), will be entered onto the EPR and sent to the service user in every case and this will be documented on the EPR
- This care plan will include the name and contact details of the named practitioner, the interventions planned, consideration of risks and how the Trust can be contacted in hours and out of hours
- Being responsible for their own interventions, plus contributing to inter-agency co-ordination meetings where SAP applies (e.g. in community teams for older people)
- Being responsive to changing needs and risks, involving other disciplines or agencies as necessary
- Named practitioners may use discretion over frequency of review as long as it is at least annually; a psychiatrist providing treatment in outpatients may agree with the service user that every appointment constitutes a review, whereas a psychologist providing a programme of treatment would be expected to review progress at the end of the programme.

Being responsive to changing needs and risks is an important aspect of the named practitioner's role. A review should always be undertaken if the service user's caring or parental responsibilities change, if other agencies become involved or if safeguarding children proceedings are begun. Thus, when complexity or risks increase, the named practitioner must record in a clinical entry that they have considered whether transfer to CPA is required and take any necessary actions that follow.

The same applies in community services for people with learning disabilities.

11. Contact and Registration

Service users make contact with Trust services through the Single Point of Access (SPA), which screens referrals and passes them to the service most appropriate to undertake an assessment.

The SPA service will ensure that wherever appropriate those referred are directed to universal or voluntary sector services that can meet their needs. Under the Care Act, those who approach the Trust or are referred for an assessment will be helped to identify what support they may need in order to maintain or improve their well-being. Screening will follow a preventative approach, accessing support in the person's local community wherever possible.

Thus when social care needs can be met through universal, community or voluntary services, or through information and advice, this will be delivered through SPA.

For further details on this, registration and information gathering, please see the SPA Operational Policy.

12. Clinical Assessment and Care Needs

Services will operate systems that ensure an appropriate professional undertakes a timely assessment, in partnership with the person who is being assessed, to ascertain whether services should be provided. Service Line Leads must ensure that details of local systems are described within the Operational Policy of the relevant service.

When a referral has been accepted for assessment, arrangements will be made for the service user to meet with a member of staff for a face to face interview.

A needs assessment leads to agreement with the service user of the areas of their lives with which they require support or treatment, and the goals they wish to work towards. The member of staff uses their own professional judgment and knowledge to decide how this might be provided and whether eligibility criteria are met. At the same time, the views of the service user are elicited on what they want and what they expect. The preferences of the service user need to be accommodated as far as possible and the whole process should be approached as a discussion between two parties who each have their areas of expertise.

As required by the Care Act, the assessment must be integrated, covering both health and social care. This does not apply for people with dementia as their social care needs are met by Adult Care Services. The person must be informed that their health and social care needs are being assessed, and the process should be proportionate, e.g. not unnecessarily complex. As far as possible administrative staff should be used to gather information and support the assessment process.

There may also be carers who can contribute their own unique perspective on the needs of the service user as well as being entitled to an assessment of their needs as carers in their own right. Staff should take account of the views of members of the social and family network about the service user's needs, including the impact which the service user's current needs may be having on carers (including young carers) and other members of the social and family network.

The initial assessment will be recorded on the Initial Assessment form on PARIS (formerly the Needs Agreement), and the Social Care Eligibility Screening Tool.

Once needs are agreed, the person referred will be told if they can be taken on for care and treatment, and what level of care they will be on – CPA or standard care.

The following tasks should then be completed by the initial assessor with administrative support:

- Offer of a Carers Assessment in line with the Care Act (2014)
- Referral of those found eligible for a full Social Care Outcomes Assessment

- Completion of clustering, or other outcomes measurement tool
- Discussion of Advance Decisions if appropriate
- Completion of risk assessment

An assessment of risk will form part of the initial assessment process. As a minimum standard this should be documented on the relevant documentation as determined in the Policy and Procedures on Clinical Risk Assessment and Management for Individual Service Users.

As part of risk assessment, safeguarding children and safeguarding adults issues must be borne in mind. See relevant Safeguarding policies for full details.

13. Entry into Care

The responsibility for ensuring the effective and timely entry of service users into care rests with the Team Manager of the appropriate team based on the GP address of the service user.

It is important that once accepted for services, every service user has a contact number immediately. Operational policies (such as the Adult Community Mental Health Services Operational Policy) will outline how this will be done in each service.

All those assessed as requiring care under CPA should have a Care Co-ordinator allocated within 28 days following assessment. If this is not possible, then that should be communicated to the service user and/or carer with an indication of when this will happen and how to contact the team in the meantime.

14. Background

The Government confirmed in "Effective Care Co-ordination in Mental Health Services" (1999) that the Care Programme Approach (CPA) was the framework for care co-ordination and resource allocation within mental health. CPA is applicable to those people under the care of Mental Health Trusts with mental health problems and the most complex needs, whether they are receiving adult (working age or older people's) mental health services, specialist learning disability services, or child and adolescent mental health services.

The Care Act (2014) describes the statutory duties of local authorities with regard to the provision of adult social care. As a Partnership Trust, under section 75 of the National Health Service Act (2006), HPFT has a duty to deliver its social care responsibilities as delegated by Hertfordshire County Council.

These duties are stated in the contractual agreement between the county council and the Trust, and are also reflected in the Social Care provision schedule of the contract between joint commissioners and the Trust.

Individuals, having been assessed by Trust services, may be deemed eligible for provision of social care under the Care Act. In such cases the relevant Trust service

will follow the processes shown in the Initial Assessment and Care Co-ordination Pack (March 2015).

In Hertfordshire, services for older people and for people with learning disabilities adopted the single assessment process. Details are given in the Health and Community Services policy "Assessment and Personalisation Procedure" (February 2015). The aim of a single assessment process is to ensure that older people and people with learning disabilities receive a more effective response to their health and social care needs. Partnership working is an essential component of the single assessment process.

However, CPA will remain relevant for some older people with mental health needs, and some people with learning disabilities when they have complex needs. People who meet the criteria for CPA Care (regardless of age) should be cared for by the CPA process. All the others should be cared for by the Standard Care process

CPA is the appropriate framework of care for service users who have a dual diagnosis i.e. a substance misuse problem plus a severe mental illness. For service users receiving treatment solely for substance misuse, services will be provided primarily by CGL who deliver the Hertfordshire Drug and Alcohol Recovery Service – a non-statutory provider (refer to HPFT Dual Diagnosis Protocol).

15. Discharge

When the Trust ceases to be involved, written information should be provided to the service user and carer where appropriate, GP and other agencies that will remain involved in care describing what is needed, from the service user, carers and other sources, for the service user to continue their recovery. This should include the service user being aware of their relapse signature.

The service user and carer where appropriate, should also be told in writing how to access Trust services again should future difficulties arise.

16. Promoting Recovery

It is very important that service users and carers where agreed are fully involved in the process of delivery of care, assessment, care planning and review.

Care plans should always reflect the goals and needs of the individual, and should always recognise the strengths and aspirations of each person.

Self-management tools such as health and well-being plans, and engagement with local community services and universal resources are key ingredients of care plans.

17. Self-Directed Support

The Care Act (2014) confirms the duty in the Health and Social Care Act (2001) in discharging the social care responsibilities of a local authority to offer payments directly to those who are eligible for community care services, to enable them to

organise their own social care rather than arranging and providing services directly for them.

It is therefore necessary to offer the option of Direct Payments to all those who meet the criteria and whose individual budgets have been costed.

This should therefore be regarded as the standard option within a Care Plan in appropriate cases. All staff with responsibility for care co-ordination need to be fully aware of their duties regarding Direct Payments under the Care Act.

18. Needs of Carers

It is essential that all staff are aware of their duties in relation to the offer of assessment and support for carers of those who use Trust Services. The Trust Carers Assessment Practice Guidance provides more detailed information with regard to who is entitled. Direct payments can be made to carers under the Care Act as one way of enabling them to continue in a caring role following an assessment of their needs as carers.

19. Capacity

Throughout the care delivery process, staff should also be aware that specific decisions with regard to care and treatment should be made in accordance with the Mental Capacity Act (2005). This Act and its code of practice make it clear who can make decisions, in which situations and how this should be carried out. The MCA provides the legal framework for Advance Decisions and Lasting Powers of Attorney.

20. Primary Care

Enhanced Primary Mental Health Services (clusters 1 to 4) are provided to individuals who do not meet the criteria for secondary mental health care. They therefore do not need care co-ordination under CPA nor Standard Care.

It is important that those using these services know who in the Trust they can contact for help both in normal working hours and outside them.

The Enhanced Primary Mental Health Services Operational Policy provides more detail.

21. Child and Adolescent Mental Health Services (CAMHS)

The CPA will be used with all service users and their families in Forest House, and C-CATT and the Home Treatment Team will also follow the CPA principles when working with a young person who is being discharged from an in-patient facility.

All others under the care of CAMHS will receive care co-ordination under Standard Care. In Specialist CAMHS this is the Choice and Partnership Approach (CAPA) – with its own version of assessment, care planning and review.

Social care services will be assessed and provided within the Common Assessment Framework in partnership with the Children Schools and Families Department of Hertfordshire County Council.

22. Specialist Learning Disability and Forensic Services

Hertfordshire

The CPA will be used with all service users receiving inpatient care.

In a small number of cases, service users with both severe mental illness and learning disability under the care of a Trust Consultant Psychiatrist may also be managed under CPA, reflecting the complexity of their needs.

Whenever the service user is also known to adult social care, their care management under the Care Act will be via Health and Community Services, leaving no care co-ordination role for Trust staff. The Trust will simply provide a named practitioner.

Norfolk

Inpatient care to service users with learning disabilities and challenging behaviour is provided in two units on this site in Norfolk.

As they are all inpatients, all these service users will receive care co-ordination under CPA.

Essex

North Essex Learning Disabilities Services comprise inpatient care, the Health Assessment and Treatment Team and community health teams.

Inpatient users and those in the community with complex needs will be managed through the Care Programme Approach.

Trust staff working in Essex will provide co-ordinated care in collaboration with social care colleagues employed by Essex County Council. Those in the community on CPA will have a Care Co-ordinator who is most appropriate to undertake the role, who may be a Trust or a County Council employee.

Bucks

In a small number of cases, service users with both severe mental illness and learning disability under the care of a Trust Consultant Psychiatrist may also be managed under CPA, reflecting the complexity of their needs.

Whenever the service user is also known to adult social care, their care management under the Care Act will be via Health and Community Services, leaving no care co-ordination role for Trust staff. The Trust will simply provide a named practitioner.

All Intensive Support Team (IST) Cases will be on CPA.

In a small number of cases, service users with both severe mental illness and learning disability under the care of a Trust Consultant Psychiatrist may also be managed under CPA, reflecting the complexity of their needs.

Whenever the service user is also known to adult social care, their care management under the Care Act will be via Health and Community Services, leaving no care co-ordination role for Trust staff. The Trust will simply provide a named practitioner.

Those who are not on CPA will have a named practitioner and they will have an assessment of their needs with a plan of care, a risk assessment and they will know the name and contact details of the person in the Trust who they can call if they need help in normal working hours.

23. Movement between Services or Trusts

Care co-ordination systems exist to ensure that there is clarity about who is responsible for services provided to each individual service user at any time. Thus it is important that when service users move, in planned or unplanned ways, between services, their care is efficiently and smoothly transferred.

Staff should also refer to the Transfer and Discharge Policy.

24. Internal

The following points in particular should be noted re internal movements:

- If a service user is admitted to an inpatient unit, their community Care Co-ordinator retains the role and responsibilities of care coordination in relation to their care. The Care Co-ordinator should maintain regular contact with both the service user, and the named nurse for the service user. The Care Co-ordinator should make every effort to attend any planned CPA reviews in inpatient units, or within the Acute Care Pathway, or make arrangements to participate via tele-conference.
- If a new service user's first contact with the Trust is an admission to the inpatient unit, or the service user does not have a Care Co-ordinator, the named nurse will ask for the relevant community team to allocate a Care Co-ordinator within 72 hours of admission.
- The named nurse has important responsibilities in the care coordination process – See Named Nurse Policy (April 2014).
- When an existing service user is offered a period of care from the Crisis Assessment and Treatment Team (CATT), the designated Care Co-ordinator actively works with the CATT and the service user in order to offer the most comprehensive service possible during the period of crisis. Joint visits and separate, but co-ordinated, visits should be routinely and regularly arranged during this period.

- The CATT assessor is responsible for completing CPA information for a new service user. For these individuals a member of the CATT will be nominated Care Co-ordinator during the intensive short period of treatment. When the period of treatment nears completion the care co-ordination role will be transferred appropriately to a member of the Adult Community Mental Health Service (ACMHS) via the CPA process. Simultaneously the medical responsibility will be transferred to a local community consultant.
- Service users who do not move from one team to another may need to be transferred from CPA to other care, as their needs change. (An example would be an older person on SAP who is admitted to an older person's mental health inpatient unit and so transfers to CPA)
- When service users move from one geographical area within the Trust to another if the stay at the new address is expected to last for more than three months and has registered with a local GP, care co-ordination, psychiatric care and care provision should transfer to the new team. In exceptional circumstances,such as some moves to rehabilitation placements, it may be in the best interests of the service user for the original team to remain responsible, in which this should be agreed promptly by the respective team managers. The best care for the service user must always be the over-riding principle rather than questions of budgetary responsibility or of service capacity.
- Those who transfer between one community team and another in the Trust for whatever reason require a review meeting, where the essential parties are the current and future care co-ordinators, the service user and where appropriate the carer.
- In Mental Health, the 7 days after transfer from acute inpatient care, and from the acute care pathway including CATT, are a well-known high risk period for many service users (see 'Transfer and Discharge of Service Users with the Care Planning Process" policy). Good transfer planning is thus as important as ever.
- People placed in in-patient Continuing Health Care will be subject to CPA, but there Care Co-ordinatior will be a ward based staff member.

The CPA meeting should at least involve the service user, the carer (where appropriate), the service user's named nurse (or their representative), their Acute Care Consultant Psychiatrist (or their representative) and the Care Co-ordinator.

25. Out of Area

Service users may move in planned or unplanned ways between Trusts and Counties.

Once the move has taken place, the current Care Co-ordinator will be responsible for sharing information as necessary with the new Trust and handing over care co-ordination responsibilities.

For those on CPA the Trust Care Co-ordinator will remain in that role until a new local Care Co-ordinator is agreed, and should convene a handover meeting in order to ensure the transition is safely managed.

The role of the Care Co-ordinator is not altered or reduced if the Bed Management and Placement Service are also involved.

When a move takes place in a planned way, which may be to independent accommodation or residential or nursing home care, the Care Co-ordinator and Consultant Psychiatrist should liaise at an early stage with their counterparts in the new area, providing such information as is required to ensure the continuation of the discharge care plan.

It may be agreed that Trust services should continue for a defined period, as long as this is both clinically appropriate and reasonably practicable. However, it may be appropriate for service users in long term placement, for instance someone placed at a maximum secure mental health hospital, for them to be discharged from care co-ordination and for HPFT to recommence CPA upon discharge if they are re-locating to Hertfordshire.

If the receiving Trust has a Care Co-ordination/CPA policy which expects attendance at a handover meeting, the HPFT Care Co-ordinator should comply with that if this is possible.

If a service user is remanded into custody in a prison outside Hertfordshire the Care Co-ordinator role will stay with this Trust.

Service users may move from other Mental Health Trusts into the care of this Trust as well as in the opposite direction.

When this happens in a planned way either from inpatient or community care, once this Trust has been notified, and if the service user is on CPA, a Care Co-ordinator should be allocated and should attend a CPA handover meeting before the move takes place if possible.

If this is not possible, the allocated Care Co-ordinator should speak to their counterpart in the other Trust and be clear when they will take over responsibility. It is very important that continuity of care is provided based on the previous care plan and risk assessment.

If the planned transfer is of a service user under standard care, transfer of responsibilities by Consultant to Consultant letter is acceptable.

When service users move from one Trust to HPFT in an unplanned way, it is just as important that a Care Co-ordinator in this Trust is promptly allocated and that this person liaises directly with their counterpart to obtain key information about the care plan and any clinical risks.

At times, there may be uncertainty about whether the change of address is likely to last. Any such doubts will not be allowed to lessen the response of this Trust to those presenting to Trust services for care. The Trust will provide a full assessment of care needs and risks, and take any necessary steps to address immediate needs, even if

this is followed by negotiation with the other Trust about who provides the future care.

Finally, it should be noted that the Care Act (2015) in sections 39 to 41 provides detailed guidance on the definition of ordinary residence, which decides which local authority is required to meet the needs of adults with care and support needs and carers.

Sections 18 to 20 make clear that local authorities have a duty to meet the eligible needs of people if they are present in its area but of no settled residence.

When accommodation is arranged in another area by a local authority or by the Trust through its delegated responsibilities, Section 39 states the principle that the person placed "out of area" is deemed to continue to be ordinarily resident in the area of the placing authority.

If in doubt staff are asked to contact a Senior Social Worker, the Consultant Social Worker or the Head of Social Work and Safeguarding for advice.

26. Inter-professional Disagreements

It is important that all staff and agencies involved in the care of the service user clearly and openly debate the issues involved in needs agreements and risk assessment and agree a single care plan which is agreed by all parties.

All staff have a responsibility to ensure that their professional views and concerns are taken note of and are fully considered in drawing up a care plan. However, contradictory or conflicting approaches to the management of risk or care plan content are not helpful and can be potentially harmful to the service user.

Where local discussions within a multi-disciplinary team or multi-agency group cannot resolve issues such as inter-professional differences, staff should inform their line managers so that issues can be resolved at a more senior management level.

A process for dispute resolution may also be necessary in a small number of cases when care is being transferred. In these situations, the respective managers will need to become involved; within the Trust all managers will work to the principles that service users must not be put at risk because of disagreements over policy, and secondly that one model or other of care co-ordination must be used for all service users.

Disputes across care groups with regard to social care should be resolved with reference to the Cross-Service Protocols Delivering Social Care Across Service Boundaries (revised 2011). Disputes across care groups with regard to substance misuse issues should be resolved with reference to the Hertfordshire Drug and Alcohol Recovery Services Integrated Governance Meeting.

27. Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:
- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;

The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary

28. Process for Monitoring compliance
Every effort is made to provide services of high quality as outlined and monitored by the Care Quality Commission and to demonstrate compliance with Care Quality Commission standards.

A number of National Performance Indicators for monitoring the performance of Trust's care co-ordination arrangements have been established by the Department of Health.

The Trust also has important care co-ordination targets to meet through its social care responsibilities, including those relating to the Care Act, Personal Budgets and direct payments.

These are subject to periodic review and amendment.

It should be recognised that the CPA has the function of gathering a considerable amount of information that is very important to the Trust's provision of evidence for performance indicators.

Information about these indicators may be sought from the Performance team at Trust Head Office.

In addition, each year in its annual Clinical Effectiveness programme the Trust will audit aspects of this policy, focussing on areas of weakness highlighted by service user surveys and learning from incidents. The Trust will continue to work with service users on ways of auditing aspects of the policy against values such as the recovery principles.

The annual National Service User survey provides an extra major source of evidence of compliance with the policy.

This revised policy will be communicated with a summary of key changes that managers are asked to use with their teams.

Information sharing between teams is monitored through:
- Unannounced CQC inspections (External)
- National Service User Surveys (External)
- Internal Quality Visits (Internal)

Results of the above are reviewed at the Quality and Risk Management Committee and Service User and Carer Engagement Group.

29. Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Part 3 – Document Control & Standards Information

Every procedural document will require a document control information section which will contain the following:

31. Version Control

Version	Date of Issue	Author	Status	Comment
V1	July 2007	Practice Governance Lead	superseded*	
V2	September 2008	Practice Governance Lead	superseded	Approved at CPA Review group Ratified at Quality and Best Value committee
V3	25th November 2010	Practice Governance Lead	superseded	Ratified at Quality and Best Value Committee
V4	August 2012	Head of Practice Governance	superseded	Reviewed
V4.1.	December 2012	Head of Practice Governance	Interim update	Minor changes due to development of practice re placements
V4.2.	March 2013	Head of Practice Governance	Interim Update	Minor changes due to further developments of practice
V4.3.	January 2014	Head of Practice Governance	Interim Update	Minor changes due to further developments of practice
V4.4	2nd September 2014	Head of Practice Governance	Interim Update	Addition to section 33.
V4.5	April 2015	Head of Practice Governance	Interim Update	Revision of roles of Care Co-ordinatorCare Co-ordinatorCare Co-Ordinatorand named practtioner; incorporation of Care Act duties
V5	25 September 2015	Head of Practice Governance	Full Review	Chairs action taken to approve
V5.1	5 July 2016	PACE Manager	Interim Update	Following CPA meetings, letters (to include summary of physical health checks) are to be sent to GP within 10 working days
V5.2	15 March 18	Compliance and Risk Manager	Superseded	The following has been included in the policy following learning from a speak up case - Prior to any CPA review that involves a decision about moving a service users care

				the coordinator and a member of the placement team must have seen the service user at their residential address in the last 3 months in order to have a current understanding of their risk, care and future needs.
V6	13/06/2019	Clinical Directors	Current	Full Review

32. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Policy Coordinator. This archive is held on a central server and copies of these archived documents can be obtained from the Policy Coordinator on request.

33. Associated Documents
The following Trust and Hertfordshire Multi-Agency Policies and guidelines (to which the Trust is signed up) should be considered in conjunction with this policy:

- Advance Decisions
- Assessment and Personalisation Procedures (February 2015, Hertfordshire County Council)
- Initial Assessment and Care Co-ordination Pack (HPFT, March 2015)
- Transfer and Discharge of Service Users within the Care Planning Process including Follow up after Discharge from Mental Health Units
- Management of Care Records
- Clinical Risk Assessment and Management for Service Users
- Admission and Transfer to Secure Settings
- Transfer of Service Users To and From PICU
- Privacy and Dignity
- Single Equality Scheme
- Hertfordshire Single Assessment Process Guidance
- Single Assessment Process for Adults with a Learning Disability in Hertfordshire
- Fair Access to Care Services in Hertfordshire
- Self-Directed Support Policy and Procedures: Interim Guidance
- Hertfordshire Child Protection Procedures
- Guidelines for Safeguarding and Protecting the Welfare of Children
- Safeguarding Adults from Abuse: A Hertfordshire Inter-agency Procedure
- Social Care Responsibilities Delegated to HPFT
- Social Care Funded Placements Policy
- Cross-Care Group Protocol (Social Care)
- ACS/HPFT Mental Health Act 1983 (as amended 2007) policies
- ACS/HPFT Mental Capacity Act policy
- Clozapine Policy

34. Supporting References

- Department of Health, (March 2008) Refocusing the Care Programme Approach www.dh.gov.uk/publications
- Care Act (2014)
- Department of Health, (September 1999) National Service Framework for Mental Health www.dh.gov.uk/publications
- Department of Health, (January 1999) Effective Care Co-ordination in Mental Health Services www.dh.gov.uk/publications
- Department of Health (March 2001) National Service Framework for Older People www.dh.gov.uk/publications
- Department of Health (January 2007) Valuing People Now www.dh.gov.uk/publications
- Department of Health (March 2002) Models of Care for Substance Misuse Treatment www.dh.gov.uk/publications
- Department of Health (June 2006) Models of Care for Alcohol Misusers www.dh.gov.uk/publications
- Department of Health (December 2007) Putting People First www.dh.gov.uk/publications
- The CPA and Care Standards Handbook, The Care Programme Approach Association, 2008

35. Comments and Feedback

People/groups involved in consultation

Service Users	Head of Practice Governance
Practice Governance Leads	Interim Chief Operating officer
Community Health Service Manager – North Essex	Service Manager – Norfolk Head of Social Work and Safeguarding
Managing Directors	Safeguarding Adults Manager
Clinical Directors	Head of Psychological Therapies and Recovery
Associate Medical Directors	Clinical Psychology Lead (AMH)
Psychiatry Lead IM and T	Lead Nurse Strategy group
Service Line Leads - CMHS	Consultant Social Worker
Community LD Services representative	SMHTOP representative

1.   Definitions

CPA – Care Programme Approach - Care Programme Approach (CPA) is the national framework for care co-ordination and resource allocation within mental health. CPA is applicable to those people under the care of Mental Health Trusts with mental health problems and the most complex needs.

Care Co-ordinator - the staff member who is responsible for co-ordinating the care of someone on CPA

Standard Care – the status of those with less complex needs who often will be receiving interventions from just one HPFT member of staff; this may be referred to as "non CPA"

Named Practitioner – the member of staff responsible for a service user's care when they are the only member of Trust staff involved

SAP – Single Assessment Process – this is the system for co-ordinating the care of those who have involvement from both the local authority and the NHS

Principles and Values

Delivery of care should reflect the following principles and values (see "Refocusing the Care Programme Approach" DoH (March 2008)):

- The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and service user/service user second.

- Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they may have, including; family; parenting; relationships; substance misuse; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

- Self-care is promoted and supported wherever possible. Action is taking to encourage independence and self determination to help people maintain control over their own support and care.

- Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported as stated in the Care Act (2014)..

- Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the Care Co-ordinator is one of the most important determinants of success.

- Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

Needs assessments and care plans that are truly individualised will be sensitive to the equalities issues that may arise). The race, culture, religion, age, gender, disability, and sexual orientation of service users and carers will be positively taken into account in planning their care with them.

Trust Responsibilities

The Executive Director of Delivery and Service User Experience is ultimately responsible for care co-ordination including CPA within the Trust and is recognised by Hertfordshire, Norfolk and Essex County Councils as Lead Officer for CPA (including care management and the single assessment process (SAP). This Executive Director is an executive member of the Trust Board and is a member of the Hertfordshire County Council Health and Community Services (HCS) Management Board.

The Executive Director of Delivery and Service User Experience may delegate any specific tasks relating to any type of care co-ordination to other members of the Strategic Operations Committee.

Operational managers are responsible for making staff aware of the policy and all staff should comply with it.

RECOVERY PRINCIPLES
WHICH UNDERPIN ALL FORMS OF CARE PROVIDED WITHIN THE TRUST

Principles of Recovery Oriented Practice, which underpin all our services are:

1. **Individual uniqueness and user centrality to service provision:** *in practice:*
    - recognises that recovery is a personal journey and unique for each individual.
    - understands that Recovery is not necessarily about cure. Recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an additional emphasis on social outcomes and quality of life.
    - places individuals at the centre of the care they receive. Through a person centred and needs led approach, individual recovery outcomes are achieved.

2. **Real Choices:** *in practice:*
    - supports people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
    - supports people to build on their strengths and to take as much responsibility for their lives as they can at any given time.
    - is proactive in supporting people to take positive risks and to make the most of new opportunities whilst balancing responsibilities for duty of care.

3. **Attitudes and Rights:** *in practice:*
    - involves listening to, learning from and acting upon the communications from individual service users, their relatives and others about what is important to each person.
    - promotes and protects people's legal and citizenship rights
    - supports people to maintain and develop meaningful social, community, recreational, occupational and vocational activities.

4. **Dignity and Respect:** *in practice:*
    - consists of being courteous, respectful and honest in our interactions.
    - involves sensitivity and respect for each individuals values and culture.
    - challenges discrimination and stigma wherever it exists both within our own services and the broader community.

5. **Respectful Partnerships**: *in practice:*
    - acknowledges each person is an expert on their own life and that recovery involves working in respectful partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.

- acknowledges the importance of the sharing appropriate information and the need to communicate clearly and to enable effective engagement with services.
- involves working in hopeful, positive and optimistic ways with people who use our services, their families and carers, and the communities within which they live, to support them to realise their own hopes, goals and aspirations.

Hertfordshire Partnership NHS Foundation Trust

Care Plans

A care plan is a way of capturing the jointly agreed plans for an individual's treatment or care. It follows the conversation that you have had with that person, and it summarises firstly the *person's goals*, and any *treatment goals,* and then *who* is going to do *what* by *when*, to help reach these goals.

All care plans should be <u>individualised documents</u> that reflect the goals of that person e.g. I want to lose five kg, I want to get out of hospital and get back home, I want to have a girlfriend etc. The person's goals may seem small ('I want to be able to cook meals for the family the way I used to' or big ('I want to get back to work') - it does not matter, the main point is that this is what is important to the individual. Any big goals may then need a discussion about how you break this down into smaller goals. There may well be other treatment aims within the plan, which may be looking at issues such as medication, therapy or other aspects of treatment.

People's needs change, and so regular reviews and amendments should be undertaken, and also reviewed at each CPA.

Tips for demonstrating care plans are person centred:

- Ensure that you take one to one time with the person, build rapport and develop the plan together.
- The care plan should capture what is important to the person, their goals for their recovery and what the person says helps them to recover.
- Document the person's strengths, passions, interests and the things that others like and admire about them. This provides a basis for a co-productive relationship between you and the person who is using our services.
- Acknowledge the fact that the person has faced difficult times in the past, if this is relevant, and has overcome difficult times before.
- Clearly document that the plan has been made together. If the person declines to discuss their views or is unable to take part in the discussion, then document, where appropriate, your efforts to make the plan together , and speak to people who know the service user, such as their family, about what is known about their wishes and what they know is important to them.
- Complement the care plan with the use of the Health and Wellbeing Plan to help the person in their own self-management.

Checklist to ensure a good quality care plan:

1. It is personalised, and does not contain 'standard phrases'.

2. The person's own goals are recorded in the care plan. There may also be treatment goals, but it is key that the person's own goals are captured, as this helps to help plan next steps to help them work towards those goals.
3. The care plan shows what the service user is going to do to help reach those goals, with clear time frames.
4. The care plan shows what staff are going to do to help the person to reach those goals, with clear time frames.
5. It captures the strengths of the person and also what the person says helps them to stay well.
6. Efforts have been made to capture the person's views about their care, using their words.
7. There are plans for what to do if there is a crisis or things go off track, and how to stay safe.
8. If the service user is not able to express their views, this is documented. If this situation may change, there is a timescale of when efforts will be made again to capture their views. If this situation will not change, it is documented that people who know the service user well (e.g. family) have been involved in developing the care plan.
9. The service user has been given a copy of the care plan, and also the carer (if permission has been given by the service user).
10. The plan is uploaded onto Paris each time it is updated.

Alison Ryan
Head of Psychological Therapies and Recovery

February 2015

References:

Top Ten Tips for Recovery Orientated Practice, Sainsbury Centre for Mental Health, 2008

NICE Clinical Guideline 136, NICE, 2011 - Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services – this provides further information on what person centred care looks like.

Personalisation through person-centred planning, DOH, 2010 – gives the background to person centred planning and examples of what this looks li

CPA Care Co-ordinator's Responsibilities

The Care Co-ordinator's responsibilities include to offer directly or oversee the delivery of the following:

A. General.

- To ensure the service user receives effective treatments and other interventions
- To ensure the service user stays safe
- To help the service user maintain as much control over his/her own life as possible, in order to pursue his/her own goals and aspirations
- To ensure social care needs are assessed in accordance with the Care Act
- To maintain and foster an optimistic, hopeful outlook with the service user, which is also based on a sound professional appreciation of the barriers to progress presented by the service user's mental ill health
- To work with service users to maximise their participation within the care provision process and to enhance service users' empowerment within the care system, encouraging self-management where clinically appropriate

B. Initial Assessment stage.
- To encourage the service user to be registered with a GP and to work closely with the Primary Health Care Team involving other professionals as required
- To ensure a comprehensive assessment (health and social care) is undertaken involving all relevant agencies
- To assess potential risks to children, under the age of 18 years and any other vulnerable members of the household
- To ensure an up to date risk assessment, management and contingency plan is in place

C. Care Planning and review.
- To act as a consistent point of contact for all parties involved in the care
- To ensure that the service user and other key individuals receive copies of the agreed care plan and a record that copy of the care plan has been given is made on the electronic service user record.
- To develop recovery orientated individualised care plans which use interventions which are evidence-based, and focused on achievable goals.
- To assist in planning and monitoring the delivery of the agreed care package and documenting and communicating decisions made about it
- To attend discharge planning meetings within and outside the County
- To remind contributors to the care plan of their responsibilities if they are not complying with the care plan
- Where new needs are identified, to take the necessary steps for them to be addressed

- To ensure the necessary services are commissioned or accessed, covering both health and social care whatever the professional background of the care co-ordinator
- To organise reviews with the service user (and carer where appropriate) in the way which is most conducive to full and open dialogue
- Where the review meeting only involves the service user, to ensure that the views of others involved in the care plan have been gathered beforehand, and that changes to the care plan are clearly communicated after the meeting

D. Social care priorities.

- To ensure both service users and carers are assessed and supported where appropriate in accordance with the Care Act
- To make sure (either directly or through a colleague) that carers are as involved as possible, from the stage of carer's assessment through to ongoing partnership working and review
- To promote social inclusion by offering choice and control to service users
- To ensure (either directly or through a colleague) that eligibility for social care is assessed, the Individual Budget process is used and Direct payments are offered as one of the tools to enable the service user to meet their social care needs.

E. Other.

- To minimise the impact of crises and hospital admissions by making sure all necessary practical steps are taken to deal with pets and other possessions by service user completion of an Advance Statement
- To provide reports as required to MHRTs and hospital managers' hearings for detained service users
- To ensure the minimum data set information is completed and updated as necessary
- To allocate and follow care pathways as appropriate
- To complete and record clustering/HoNOS scores (and/or other outcomes measurement scores)
- To organise safe transfers of care between teams or between Trusts
- To ensure Service Users are aware of their right to complete Advance Decisions and Advance Statements

Administration of the Mental Health Clustering Tool / Cluster allocation

- Having a service user allocated to a Care Cluster will in future ensure the Trust receives funding for the services we provide to that individual

- A Care Cluster is a description of 'needs' related to the individual utilising our service

- There are presently twenty Care Clusters, these are broken down into three distinct areas relating to the origin of the problem; **Non-Psychotic, Psychotic or Organic**

- Clustering can be applied following assessment of an individual, either at entry to our services, crisis points or when needs change. At CPA reviews clusters should be reviewed; individuals may remain within the same cluster, or step up or down a care cluster

- Care coordinators, who are qualified professionals, are expected to allocate care clusters to their service users during the hours of 9am-5pm, Monday to Friday.

- A small number of service users do not have a Care Co-ordinator in the Trust as they are "CPA exempt". For these, the person from the Trust who has involvement (the primary worker) is responsible for doing the clustering.

- **OUT OF HOURS:** If a known service user makes an emergency presentation, the key professional involved during this presentation is required to complete a needs assessment and hence care cluster the individual as part of this process. This is likely to apply to CATT, A+E liaison and IOT services

- **NEW PRESENTATIONS TO SERVICES:** A mental health professional would assess an individual and identify their needs. At this point the key professional involved in this process will then cluster the individual

Care Co-ordination and Placements

As part of care planning, care co-ordinators will sometimes be responsible for making arrangements for a service user to receive care in a registered care home or in a supported housing project.

The Social Care Funded Placements Policy (August 2012) describes in detail the process to be followed in identifying a placement and securing the funding.

As part of this, it is crucial that there is clarity of roles between the Placement Service, the Care Co-ordinator and the responsible Consultant Psychiatrist.

The responsibilities of the Care Co-ordinator in this area are as follows:
- Make the case to the placement panel providing all necessary information as required
- Consider the suitability of any proposed placement for the individual concerned and state in writing on the checklist (appendix 11) whether the placement is judged to be acceptable. This must include a pre-placement visit to the resource.
- Keep interested parties – above all, the service user –informed about the progress of the placement search
- Review and update if necessary the risk assessment, after the panel decision to place and before the placement starts. As long as the Care Co-ordinator and team manager have reviewed the risk assessment after panel, there is no longer a requirement to update the risk assessment in the 48 hours before the placement begins

- Ensure the suitability of the placement is checked by convening review meetings as necessary in response to significant changes in needs, and at least annually

The team manager will always confirm before the placement starts that they are happy with the completion of the checklist and the latest risk assessment, and will authorise that the placement is safe to proceed.

The tasks and the respective responsibilities of key staff in agreeing placements are shown below.

In mental health services for older people, the funding arrangements and placement service are different and subject to change. However, where the Care Co-ordinator role is held within HPFT, the Care Co-ordinator in these cases must follow this policy so that placements made by Trust staff are safe.

When the service user being placed is on clozapine or other complex medication, the Care Co-ordinator should be a nurse. This is to ensure that the arrangements for ongoing medical treatment are safe and clinically appropriate.

The identification of a suitable placement must include an assessment of the ability of the establishment's staff to care for those service users who are on complex medication.

When the service user being placed is on complex medication, the requirement for a review of the risk assessment before the placement starts must include assessment of the competence of staff in the home to safely manage service users taking complex medicines which need strict monitoring and adherence.

Funded Placements For Social Care Placements ONLY – Checklist 1.

Guidance for completion:

1. This form starts with the Placement Team
2. Following the Panel Approval, the Placement Team will complete the first section of the form, and it will be emailed with the Panel Decision to the Care Co-ordinator.
3. The Care Co-ordinator completes the second section of the form and scans it onto the client's entry on PARIS, clearing identifying it as a Pre Placement Check List.
4. The care co-ordinators team manager needs to approve that the placement is safe to proceed by completing the final section of the form prior to it being scanned onto PARIS
5. Audits of the completed forms are to be expected; line managers may also choose to audit forms as part of supervision.

Action	Placement Team
Having identified a possible placement following the Panel, check that it is CQC registered (this does not apply to Supported Living Provisions, who are not required to register with CQC)	
The Inspection Report Link will be attached, **this should be read by the Care Co-ordinator and any concerns raised with the Provider**	
Confirm provider is registered for the care group which represents this service user	
Check that there is a valid contract with HCC Contracts Department	
Enter price agreed at Panel for Placement (and if there were any extra staffing costs approved)	

Name of Placement	
Placement Team staff member	
Service User Name	

Date of completion	

Action	Care Co-ordinator
Having received approval from the panel, arrange for the placement provider to assess the Service User	
If accepted by the Placement, visit the Placement with Service User	Date of Visit:
Risk Assessment updated and shared with provider	Date reviewed:
Request from provider evidence that all staff are CRB approved	
Check that the establishment's Statement of Purpose is clearly displayed (CQC requirement)	
Seek and record service user views on placement	
Seek and record (where appropriate) carer views on placement	
Consider suitability of the environment for service user (eg. mobility issues, sufficient space)	
Consider suitability in terms of level of security (eg. are there more restrictions than are necessary for this service user?)	
Consider suitability in terms of equalities (eg. diet, gender mix, spiritual needs)	
Consider suitability in terms of available activities, recovery-oriented social opportunities and model of care	
Consider competence of staff re medicines management	
On basis of all the above, record whether placement is satisfactory and scan completed checklist onto care-notes	

Care Co-ordinator signature	
Team	
Date of completion	

Action	Team Manager
Confirm Checklist completed satisfactorily	
Risk assessment reviewed and remains current	
Confirm placement is safe to proceed	

Team Manager signature	
Team	
Date of completion	

Sharing Information with Service Users

The Trust's services are based on the recovery model which demands that service users are fully informed about all aspects of their care, so that they can wherever possible make informed choices about their care and treatment.

When a new person is being seen for agreement of their needs having been referred to the Trust, staff should ensure that information about services available is fully shared so that an informed decision is reached. This includes cases where Trust services are not needed but where staff still have an important role in "sign-posting" individuals to other resources.

When an individual is taken on for services from the Trust, the information that is likely to be most important to them will include:

- Their care plan and Care Co-ordinator or recovery partner (and their contact details)
- A crisis plan including sources of support out of hours such as the mental health helpline
- Information about how services are organised (this may well be provided through a welcome pack)
- Information about practices within the Trust such as complaints procedures, rights of access to records and the protocol on sharing information with other agencies
- Information about diagnosis and medication including side effects – both written and discussed
- Information about psychological and other treatments – both written and discussed
- For those who meet fair access to care criteria, information about personal budgets
- For carers, information about their statutory rights eg. to a carer's assessment

When a new service is introduced, or there is a significant change in the care plan, or there is a review, the need for information-sharing should be considered again. It is important that the process for information-sharing forms part of an ongoing dialogue between service user and staff, rather than being a fixed task at fixed points.

On discharge too, service users should be informed both about sources of assistance outside the Trust and about the simplest route back into Trust services.

Information should always be discussed sensitively bearing in mind the mental health of the individual and their unique circumstances. For example, psychiatrists should ensure that questions of diagnosis are discussed face to face, and on no account should a diagnosis be first disclosed to a service user when they see a copy of the clinician's letter to their GP.

Whilst potential risks of sharing information should be borne in mind, this should not be allowed to lead to a culture of withholding information so that service users have lower expectation and so can be easier to manage. This is especially important with regard to inpatients detained under the Mental Health Act.

Sometimes alternatives can be used, such as when working with older people with dementias where it may be more sensible to share information with carers as long as questions of consent and capacity have been addressed.
The information shared should always be recorded in the electronic patient record.

Information Systems, Documentation and Training

The Trust is committed to underpinning all types of care co-ordination including CPA with an Information System able to offer the following key functions:

- To ensure information about service users is available to all appropriate staff whenever and wherever required.
- To assist staff and their managers in managing case loads
- To assist in service planning and improvement
- To provide countywide information to assist and inform audit requirements and monitoring of performance against targets.

In addition to the Trust Electronic Patient Record System, currently Paris. Trust staff may be required to use other electronic patient record systems relevant to their particular area of work. Operational Policies for services will outline the requirements for recording on all electronic patient record systems relevant to the particular service area.

Commissioning information for social care services will be entered onto the Adult Care Services system.

Team managers should ensure that their staff make full use of the EPR manual and of EPR training opportunities.

The care co-ordination process on the EPR is outlined in Appendix 8.

This revised policy will be issued to managers with a summary designed to help them communicate the key points of the policy to staff in their teams.

The Trust provides training on the values, skills and knowledge required to be an effective Care Co-ordinator. Together with service users and carers, the Trust will continue to develop a programme of training on care coordination process, which all staff who support the process will be encouraged to attend.

All staff who co-ordinate care should also complete the Trust Equality and Diversity training to contribute to their competency as a Care Co-ordinator.

Communication and Confidentiality

Issues of good communication and of sharing relevant information amongst members of the multi-disciplinary team, and any agencies involved in the care plan, are fundamental to the operation of an effective co-ordinated service and yet may appear, at times, to be at odds with the safeguards around confidentiality which are required by many professional organisations.

The key to successfully treading this course is to ensure the service user is consenting to the sharing of relevant information with other agencies and carers who have legitimate grounds for being advised of such information.

Those in the role of Care Co-ordinator/named worker should explain the Trust's policy on information sharing at first contact with the service user. The advantages of the service user making an advance statement to clarify what they wish to happen in this area will also be useful.

Discussions with service users about sharing information with other agencies and carers should be documented in the care record.

However, in all cases there needs to be a final judgement by the relevant Consultant and/or Care Co-ordinator/Named worker as to whether there may be sufficiently strong grounds for over-ruling the request of a service user who has asked that information should not be shared with other disciplines/agencies. This may be considered appropriate where it is judged that the public interest outweighs the duty of confidentiality. Issues of safety to the public, carers, staff and children may take priority over an individual's right to confidentiality.

Information for Service Users/Carers

Information leaflets for service users/carers that outline the principles of CPA and other types of care co-ordination and its application within Hertfordshire will be routinely issued in all clinical settings and available in leaflet racks throughout Trust services. An easy-read version of the leaflet is available. Information will be provided in different languages and formats as required.

The Trust web site will carry up to date information and is accessible by service users and carers.

Equality & RESPECT

The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers – and subsequent support for staff.
The RESPECT campaign is designed to ensure that all services are mindful of the following in giving care to service users and support to carers and staff:

R – Rights & Recovery
E – Equality & Dignity
S – Safeguarding
P – People as People
E – Excellent staff who are engaged, empowered and compassionate
C – Choice and Communication
T – Transparent & Fair Services

Delivering equality & RESPECT is also about ensuring the needs of protected groups are upheld at all times and assessed appropriately on entry to the service. This includes the needs of peopled based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief and sexual orientation. In some circumstances it will also be necessary to take account of specific needs re: pregnancy and maternity.

The Trust is opposed to all forms of discrimination and works to ensure a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where situations of inappropriate behaviour occur, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must take full account of needs relating to all protected groups. This includes age, disability, ethnicity/race, gender, gender reassignment, marriage/civil partnership, pregnancy/maternity, religion/beliefs and sexual orientation.

In sharing information, staff will be sensitive to the mental state of each service user, returning where necessary to give information when the service user is well enough to appreciate it.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

A minimum requirement consistent with the promotion of equality of opportunity for service users and carers is to make all reasonable efforts to ensure that an appropriate interpreter is able to facilitate communication between Trust staff and service users and carers if their preferred spoken language is not English including ensuring availability of British Sign Language (BSL) interpreters. This includes, in

particular, all ward and care co-ordination meetings, Mental Health Act assessments, Mental Health Review Tribunals and Managers Reviews.

Service users and carers should be helped to overcome other barriers to communication through provision of other sorts of assistance, such as hearing loops and easy-read versions of written information where necessary.

The Trust policy on communicating with service users from diverse backgrounds should be used in conjunction with the policy on service user Equality Monitoring.

Embedding a culture of RESPECT

All staff must be aware of issues relating to equality, diversity and RESPECT for service users and carers including:

- Understanding how to ask questions about culture, religion and ethnic background
- Arranging interpreters where necessary
- Offering adaptations for people with disabilities e.g. Hearing Loop, Downstairs meeting rooms etc.
- Opportunity to discuss relationships and issues relating to sexual orientation.
- Ensuring that people do not suffer disadvantage due to age and are dealt with appropriately within services
- The needs of both men and women are represented equally – including the needs of transgender service users.
- Staff have a responsibility to challenge discrimination they may witness and report back in accordance with risk management and complaints and incidents processes.
- Staff must also be aware of issues relating Human Rights including how they apply to staff and service users.

Appendix 10 Access for People with Learning Disabilities

<u>The Trust policy statement re access to healthcare for people with a learning disability states:</u>

All mental health services in HPFT are potentially available to people with a learning disability.

HPFT have a responsibility to ensure that all people with a learning disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that

- Reasonable adjustments are made to ensure that each person has the same opportunity for health, whether they have a learning disability or not. (Equality Act 2010)
- Assume that each person presented to the service has capacity. If assessment shows they don't, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)

Adjustments will include:

➢ spending time with the individual to gain an understanding of their preferences for treatment
➢ To ask them where they would prefer to be treated,
➢ To provide additional support to assist with communication, this support will be available via easy read material/and/or audio equipment. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
➢ If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
➢ All people with a learning disability should have a Health Action Plan (Valuing People) and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
➢ To value and welcome the contribution of the relative/carer/advocate

we are...   you feel...

Our Values

we are...	you feel...
Welcoming	✅ Valued as an individual
Kind	✅ Cared for
Positive	✅ Supported and included
Respectful	✅ Listened to and heard
Professional	✅ Safe and confident

Our ✅alues

Welcoming Kind Positive Respectful Professional